Selected Papers on
THE AGING

Presented at the

79th Annual Meeting of the

National Conference of Social Work

May 25-30, 1952, Chicago, Illinois

National Conference of Social Work
22 West Gay Street — Columbus 15, Ohio

Published by
Health Publications Institute, Inc.
Raleigh, North Carolina

FOREWORD

When the Executive Committee of the National Conference of Social Work, in March, 1951, decided to return to a single volume of official Proceedings, supplemented by low-cost volumes of selected papers, it was agreed that these low-cost volumes might be of two types: (1) for persons functioning in a particular area, i.e. casework, group work or community organization; and (2) for persons concerned with a special problem area, no matter what their specialty.

This volume of papers related to the aging falls within the second category. The decision to publish it was made by the Editorial Committee when it realized that a number of valuable papers on the subject had been presented at the 1952 Annual Meeting. The Committee was aware that not all these papers could be included in the Proceedings, nor were they all suitable for that purpose. In addition, the Committee felt that the papers would have wider circulation, and therefore perhaps greater usefulness, if they were brought together in a small volume which could be distributed at a minimum cost.

This pamphlet is a joint undertaking of the National Conference of Social Work and the Health Publications Institute of Raleigh, North Carolina. The Conference is glad to be able to make available these papers dealing with a subject in which there is such a great interest at the present time.

The papers were read and the Introduction prepared by Lucia J. Bing and Margaret W. Wagner of Cleveland, leaders in the field of work with the aging. The Conference is grateful for their interest and assistance in this project.

Joe R. Hoffer
Executive Secretary

July 10, 1952

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INTRODUCTION

The fact that little is known or understood of the normal process of aging came to most of us as a revelation. We had merely accepted the fact that the years took their toll and that the body wore out, without concerning ourselves with the older person as an individual. In a culture where attention is focused on youth, the older generation was lost sight of until the increasing numbers of dependent and physically incapacitated older persons placed a burden on our economy and an increasing strain on the family.

In the past decade many branches of science have applied their divergent skills to the problem of aging. We find contributors from medical science, psychology, sociology, economics, anthropology, and lastly, from the field of social work. So far the findings are related to a specific branch of science or skill without apparent inter-relationship. The concern of the social worker is within the area of the emotional and physical needs of the individual, his motivations of behavior and how he may be helped to retain his competence as a useful citizen, and to live a more satisfying life.

The growing concern has been expressed in a considerable amount of printed material, but as yet only the surface has been scratched. The field of social work has made a negligible contribution to the accumulated recorded data, yet if we are to reach a basic understanding of the aging individual as a human being, the social worker has a very important role to play. The decision of The National Conference officers to collect and publish a pocket edition of selected papers on the aging, presented at the 1952 Annual Meeting, is therefore most commendable.

There were some difficult decisions in selecting papers which should be included in this small volume. Objective recordings have value even in the experimental stage, for they record progress. It must be recognized that the social worker who has developed skills and techniques in dealing with younger groups finds herself twenty-five years behind the times in approaching the problems of aging. Part of this is due to a resistance based on misconception of the older person as a "has been," who cannot change, grow or be helped.

The papers in this publication were carefully chosen for the reason that they describe and clarify specific aspects of the problem and have a contribution to make. Other papers were not

included because either data was lacking to support a theory or program, or because they contributed little that was new. The Committee believes that the papers selected for this small volume will be informative and helpful and hope they will provide an incentive for continuing contributions from the social work field. The field is wide open for study and experimentation and the demand for information is very great.

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INDIVIDUALIZING THE AGED

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There are two major topics which I shall discuss in this paper. First, I shall present some of the important *psychological considerations* which should be borne in mind by those who work with older people. And then, secondly, I shall discuss the subject of *therapy*.

As a starting point, it might be well to take a bird's eye view of our general attitude about the aged. In recent years, the rocking chair has been discarded as a symbol. An attitude of pessimism has given way to one of optimism. In some instances, the pendulum has swung too far. The latter years of life are at times pictured in terms which are too glowing. While these years are not necessarily ones of physical and mental deterioration when little can be done, neither are they a period in paradise nor a golden age when nothing need be done.

If we are to deal effectively with older people our attitude must be a realistic one. A consideration of some of the psychological problems should help us in our efforts to develop a sound approach.

General Psychological Picture

It is possible to understand many of the emotional reactions of older people if we consider the stresses of the latter years of life and their effects upon the pre-existing personality structure. The most common stresses are physical and mental limitations or disabilities, retirement, loss of relatives and friends and rejection by children. To be sure, the hardships to which some people are subjected are very light while those which others must bear are very heavy. Moreover, the effect on the individual lies not only in the degree but the type of stress. A mild stress which hits a weak spot may be as disruptive as one of greater magnitude which strikes a relatively invulnerable area.

Physical and mental limitations, retirement and the loss of relatives and friends most often produce their effects in two important emotional areas. These are the areas of *self-esteem*

and *dependency* (one's needs for emotional sustenance). When latent but intense conflicts about self-esteem or dependence are mobilized by a stress, a serious emotional upheaval may result. When, on the other hand, these areas are not unduly vulnerable, the reaction to the stress may be appropriate and relatively mild.

As it has already been stated, the individual's response will depend upon the severity and the kind of stress and upon the previous personality structure.

Reactions to Loss of Self-Esteem

With this as a background, we can now consider some of the reactions to loss of self-esteem. These reactions are evoked by stresses such as heart disease and arthritis, which limit activity, loss of physical attractiveness and enforced retirement. They occur because the stresses disrupt old methods of keeping an unacceptable picture of oneself submerged. When external reassurances, derived from productive work and beauty, are no longer available to combat the unacceptable picture stemming from early childhood when the basic attitude about oneself was formed, the hidden feelings threaten to emerge. Those people who suffered the most intense early injury to their self-esteem and who were most dependent upon a single method of obtaining external supplies are hardest hit when stresses upset their pattern of living.

Various defense mechanisms which protect the individual from experiencing anxiety are called forth to cope with the effect of the stresses. Gitelson[1] cites the case of a business-geared man who had a heart condition which required a reduction in his activities. The patient reacted to this threat by declaring that his associates and his physicians were plotting to get him out of business.

Alexander[2] reports the case of another business-geared man of sixty who developed a street phobia which prevented him from going downtown to his office. It was easier for this patient to tolerate his symptom than it was to face the fact that he was declining and being eased out of his business position.

In these two cases the narcissistic blow resulted from an

[1] Gitelson, Maxwell, "The Emotional Problems of Elderly People" in *Geriatrics* (May-June, 1948), vol. 3, p. 135.

[2] Alexander, Franz. "The Indications for Psychoanalytic Therapy" in *Bulletin of the New York Academy of Medicine* (June, 1944), vol. 20, p. 219.

inability to continue at work and the loss of this source of *prestige*. Very different mechanisms of defense, however, were called forth. One man used paranoid projection and the other resorted to a phobia. Both were work-centered individuals who had not developed secondary ways of obtaining meaningful external supplies. When the prime method of holding feelings of worthlessness in check was taken away, an emotional illness resulted.

Still another business-geared man who feared that he was ill and would have to retire committed suicide on the day before he was to receive the physician's diagnosis.

It is a frequently repeated story that a man or woman who has seldom been sick retires only to suddenly become ill and die within a few weeks. We might wonder if some of these deaths are concealed or unconscious suicides.

The situation that exists when beauty is all-important is illustrated by the case of a fifty-five year old woman who, as a result of an early disturbance in her relationship with her mother, felt unlovable and undesirable. She attempted to protect herself from any further trauma in this sensitive area by settling for an inferior substitute for love, namely admiration. Moreover, she needed admiration to combat her own unacceptable picture of herself. Since she was a very pretty woman, it was not difficult for her to produce the effect upon men that she desired. This held her own feelings of worthlessness in abeyance for years. When her beauty began to fade, however, she felt extremely threatened. She spent long hours looking into the mirror to reassure herself. She went on frequent shopping tours looking for clothes that would enhance her beauty. When these efforts failed to hold her doubts in check, she became seriously depressed. It was only when she felt sure of her own lovability, after more than a year of psychotherapy, that she could accept aging with relative tranquillity.

The situation in the cases cited can be summarized in this way: These were people who sustained early injuries to their feelings of self-esteem. Since they did not feel lovable and did not dare to reach out for real object relationships, they settled for the goal of being admired. Moreover, narcissistic needs were intensified because of the narcissistic injuries. During their youths they were sustained by the "hope of youth" and their struggle to achieve the intermediate goal which they had set for themselves. During adult life they received the external supplies they sought as a result of their work or, in the case of the woman,

as the result of her beauty. They remained in a state of emotional balance as long as their needs were sufficiently gratified. It was only when one of the stresses of the latter years of life interfered that they "decompensated." Since they had no alternate way of maintaining a balance, an emotional illness resulted.

Thus far we have considered some of the reactions (neurotic and psychotic in type) which occur when a stress deprives a person with a deep narcissistic wound of his major means of defense. Now how does a man who suffers from no such wound react to the feelings of uselessness or inadequacy which result from retirement or illness? He may use some of the defenses which are so common in older people that they help to form part of the stereotype of the aged. Among these are, 1) a turning to the past, 2) a refusal to try new things and a set way of doing things, and 3) a self-assertiveness to the point of being domineering. It should be stated parenthetically that for discussion purposes a sharp line has been drawn between these reactions and those mentioned in the cases cited previously. Actually there is no sharp division, but rather a shading from one group into the other.

A turning to the past is a turning to a period of greater competence. One dwells upon old triumphs to relieve or to turn away from current feelings of inadequacy or helplessness. In this connection, we should remember that one of the legitimate pleasures of old age comes from a sense of satisfaction derived from past achievements—from a job well done. Only when the turning backward becomes too pronounced and too distorted in content should we suspect that the reaction to stress is inappropriate.

It may also be mentioned that people who have a real record of accomplishment to fall back on are fortunate. Others may resort to embellishments of the past or even fantasy.

There are psychiatrists who believe that some memory loss for recent events is related to this turning backward. Gitelson[3] has suggested that the memory loss may be based upon a combination of organic (brain) changes and psychological factors. The chief psychological factor is turning away from difficulties in the present. While this throws a more hopeful light upon the subject of memory loss, it remains to be seen if the emotional factor is significant. It is my impression, based upon the fact that memory impairment is so often accompanied by other signs

[3] Gitelson, Maxwell, *op cit.*

of pathological brain changes, that psychological factors probably play only a minor role in aggravating the memory loss.

A refusal to try new things and a tendency to develop very set ways is an entrenchment. As we grow older, habits become fixed and we trend to cling to methods that have served us well. At the same time, even in a very flexible person, it becomes more difficult to learn with advancing years. Very few people in their forties will learn to drive a car as quickly or as proficiently as a teen-ager. When the entrenchment is in keeping with the actual physical and mental state of the person, it should be regarded as an appropriate regearing. Only when it is out of keeping with the real situation should it be regarded as an expression of an emotional difficulty.

We often find it easier to understand and to accept physical entrenchment than emotional entrenchment. It is generally considered a good idea for older people to move to a warm climate where the adjustment demands at a physical level are reduced. Our ideas in regard to emotional adjustment will have to be geared in a similar way.

In discussing the self-assertive and even domineering behavior of older people, Gitelson[4] states: "These tendencies are compensatory reactions for the feelings of inferiority and inadequacy which have been engendered by actual physical and psychological decline. The loss of centrality of position in the family group or in the person's work, the sense of loss of social status through actual or relative decline in occupational status, general cultural attitudes towards old age as a period of necessary and actual failure—something which is pitied but without real sympathy by those younger—these are some of the factors that produce the feelings of insecurity and inadequacy that result in the reactive cantankerousness of some elderly people."

Often domineering or even dictatorial behavior is simply an intensification of a life-long character trait. This may be true, also, for gullibility, which, among other things, makes it possible for some people to obtain and to accept a larger share of external supplies. Often seen, too, among older people is a regearing of their value system which permits them to take pride in and receive gratifications from accomplishments which previously would have had little meaning to them. Thus a man at a home for the aged may brag that he is one of the few really able-bodied men there, that he is the best singer or that no one runs the elevator as well as he does.

[4] Gitelson, Maxwell, *op. cit.*

While there are many other defenses which may be used to cope with the blows to self-esteem suffered by older people, the ones which have been mentioned should serve to illustrate the essential dynamic processes. Of course, many combinations of defeneses can and do occur.

Reactions to Increased Dependent Needs

Next to problems centering about the person's feeling of self-esteem, the stresses of the latter years of life most often mobilize conflicts in connection with dependency feelings. Just as there is often an actual narcissistic injury there is often a real increase in dependent needs. In both situations the more severe responses occur when a latent conflict is mobilized.

In the case of Mrs. A., a seventy year old woman, a marked reaction resulted when a weak spot was assaulted. She had been in good health until her seventy-five year old husband had a "stroke" which left him invalided. After the initial critical period of Mr. A's illness, she developed a severe diarrhea accompanied by marked abdominal distress. There were also many anxiety symptoms. She could eat nothing but baby foods and she drank large quantities of milk. She dropped all of her activities, constantly talked of her symptoms and was very demanding of attention. When the family physician told her that her husband would never be any better, that she would have to adjust to him as he was and that, if necessary, she would have to treat him like a "helpless baby," all her complaints became more marked. Not only was she under more tension than before, but her relationship with her husband became so disturbed that she made it extremely difficult for him. At this point she was referred to a psychiatrist. It was learned that Mrs. A. had been the oldest of ten children and that long before her own dependent needs had been met, she had been called upon to take care of younger siblings.

In this instance a stress played directly into a childhood conflict. The patient's reaction was one of regression to a very dependent state. At the same time, there was a marked jealousy and resentment of her husband which created considerable guilt.

The case of Mrs. C., age sixty-eight, is another one in which dependency feelings play a major part. This patient had worked "with a will" from the age of eight when she began to help her sickly mother with household chores and the care of two younger brothers. In her adult years she had nursed her mother and later her husband. When they died, she took a position as a

companion and remained at this job until it became necessary for her to have a breast operation. From that time on she felt that she could no longer work, and she entered a home for the aged. After being there for a short time, she fell and fractured her left femur. All the efforts of the physicians, physical therapists and occupational therapists failed to get her out of bed when she was physically able to be up. At times during the next three years, the regression was so marked that she would not even feed herself. Her general attitude was that of a demanding child who reacted to mild frustration with temper tantrums and tears.

In this instance the patient's dependent wishes had been covered over by doing things for others. At the same time, she derived some gratification of her own longings by identifying with the people she nursed. After the breast removal and fracture, when she could use illness as a justification for her demands, her dependent cravings were expressed directly. Thus illness fostered the breakthrough of intense latent desires and resulted in a marked regression.

A third patient, Mrs. S., age seventy-four, had maintained an apartment for a sickly brother until she had a "stroke." During her hospital stay she gradually regained most of the function in her affected arm and leg. She was sent back to her apartment to live with a practical nurse. In the meantime, other living plans had been made for her brother. She reacted to the new arrangement with the feeling that she had been rejected. After a half-hearted suicidal attempt she was very remorseful. Her whole attitude changed when a daughter asked her to move in with her and showed an eagerness to have her. The patient said, with tears in her eyes, "You don't know how important it is to feel wanted."

In this instance the train of events had touched upon a sensitized area. The emotional disturbance quickly subsided when the feeling of rejection was relieved.

These three cases are presented to demonstrate the fact that a wide variety of responses may occur when stresses mobilize latent dependency problems. The reactions vary considerably, mainly because the predisposing factors are highly individual.

At the other end of the scale are people who are isolated because of physical disability or other causes, and thus cut off from dependent gratifications. Their desires are neither greatly increased nor conflict-laden. These people may react to the

deprivation of their realistic needs with mild despondency or hypochondriasis. The symptoms rapidly subside when external emotional supplies are forthcoming. It is for this reason that these people benefit greatly from the human relationships made available in golden age programs and in homes for the aged.

Orientation for Therapy

The focus in this paper has been on the self-esteem and dependency problems of the aged because these are the ones most often seen. It should be remembered, however, that many other conflicts may be mobilized.

In a general way, two types of reactions have been described under each of the headings, *Reactions to Loss of Self-Esteem* and *Reactions to Increased Dependent Needs.* The first occurs when the predisposition plays the main role in shaping the clinical picture. The second is seen when the predisposition is minimal and when the stress exerts its effect by depriving the person of realistic needs. These two groups have been sharply delineated for discussion purposes. Actually one group shades into the other so that many admixtures occur.

Our therapeutic efforts, if they are to be well suited to the patient, must be based on a thorough history and a careful evaluation. When the older person suffers from a deprivation of realistic needs we should do whatever we can to fill these needs. In some instances, acceptance by and supportive help from a social worker will be of benefit. In other cases, golden age clubs and homes for the aged will fill a void. When a person has turned to the past or developed fixed ways of doing things to derive narcissistic gratifications or to protect against injuries to self-esteem, we should *not* tamper with these defenses unless we are sure that we can provide adequate substitutes for them.

When the predisposition plays the major part in shaping the emotional disturbance there are additional therapeutic considerations. For the most part, procedures which aim at effecting fundamental personality changes are not used in treating the aged. Freud[5] made the statement that people near or over the age of fifty could not be psychoanalyzed. The general rule still holds although there are occasional exceptions to it. Perhaps the best explanation for the fact that analysis is not a procedure for people in their fifties and over is that there is not enough

[5] Freud, Sigmund, "On Psychotherapy" in *Collected Papers* (London: Hogarth Press, 1946), vol. 1, p. 249.

to hope for in the future to provide the motivation needed to endure the tensions mobilized by analysis.

Therapy in which insight is given into the nature of a major conflict is sometimes used but much less often than in other age groups. Alexander[6] was able to achieve a successful result with this type of procedure in a sixty-six year old businessman who developed chronic alcoholism and spastic colitis after his retirement. Interpretation of the emotional difficulties of retirement involving hurt prestige and envy of youth were met with considerable understanding. In the case of the patient with the street phobia, however, a tentative interpretation was met with great resistance and a flight from treatment.

With Mrs. A., whose sibling and dependency conflicts were mobilized by her husband's "stroke," when a trial interpretation produced a poor response another tack was taken with good results. Efforts were made to reduce the stress. She was supported by me in some of her demands and a program consistent with her physical and emotional condition was worked out. It was possible to get the family physician and relatives to decrease their pressure by explaining to them that unless they eased up, Mrs. A's reactions would either make things more difficult for her husband or become so marked that hospitalization would be necessary. Since the patient came in from out of town it was possible to see her only once a week. Even with this arrangement she showed some immediate improvement and within a month she was relieved of most of her symptoms and doing well in her relationship with her husband. Visits were then spaced. At the end of four months she was back to her usual activities and therapy was terminated.

For the most part, supportive types of therapy are used in the treatment of the aged. These include reassurance, environmental manipulation and direction or counseling. The goal is to reduce a stress or to bolster a weakened defense system. Although psychoanalysis or intensive psychotherapy is seldom used, it is still important to have a thorough understanding of the psychodynamics of the emotional illness. Such an understanding should be employed as the basis for selecting an appropriate or an effective plan of treatment using supportive measures.

In a previous paper,[7] I have discussed the ways in which

[6] Alexander, Franz, *op. cit.*

[7] Hollender, Marc H., "Role of the Psychiatrist in Homes for the Aged" in *Geriatrics* (July-August, 1951), vol. 6, p. 243.

the psychiatrist at a home for the aged can work with the personnel who have a sustained relationship with the residents. What I have said about the psychiatrist might also be said of the social caseworker within this same setting. The worker can counsel with the personnel and carry through a therapeutic program in this way.

Although the relationship of the psychiatrist or social worker to an older person has some superficial aspects that are different from that of a therapist to a younger person, basically it is still rooted in the early parent-child attachment. The aged individual feels toward the therapist as he feels toward an adult son or daughter—but a son or daughter who would be like a parent to him. In many instances this attachment may become much more intense than is immediately apparent.

In summary it may be stated that while uncovering types of therapy can seldom, if ever, be used with older people, supportive forms of treatment selected on the basis of a sound evaluation can accomplish much by helping to reestablish an emotional balance which has been shaken by the stresses of the latter years of life. Some of the special considerations which arise in the evaluation and treatment of people suffering from senile or arteriosclerotic dementia will be discussed in another paper.

HELPING THE OLDER ADULT TO KEEP RELATED TO THE MAINSTREAM OF COMMUNITY LIFE

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Group life is normal life. No longer is the home the basic unit of society for the older adult. It is, rather, the community of associates among which he moves.

Social scientists have recognized the importance of group membership as one of the prominent factors of modern social life. Belonging to a group is such a natural and accepted pattern of living that usually little attention is accorded it. All too often, only when these groups became a liability to society, are they consciously recognized. The positive force of these groups as a deterrent to individual deterioration must be extended to include the older person who no longer has such a unit to which he may belong. That which has been an integral part of his life has vanished. The associations with others which provided the necessary stimulation to invoke continuous development of interests and abilities, subject only to the capacities of mind and body, are now gone.

It is generally recognized that the older adult deteriorates rapidly as soon as he is relegated to the scrap heap of productivity, with few opportunities to retain normal group ties. The need for belonging and being an integral part of groups begins early in life, and by the time a person is older the necessity of remaining a spoke in the wheel of the group has been bolstered by a great number of varied associations. Lack of such a group bond may easily result in maladjustment and insecurity which, in turn, may promote actions which are in conflict with accepted standards of conduct.

A person without group ties lacks a definite social anchorage—yet people in the older age bracket all too frequently find their attempts to secure such an anchor frustrated. It becomes impossible for a person to adjust to a group if the group refuses to adjust to him, and as a direct result of a great complex of factors, among which have been our rapid urbanization and emphasis on a youthful America, more and more groups in our society are refusing to adjust to the older citizen. Faced on all sides by this social "cold shoulder" the senior adult's opportunity

for social interactions lessens and then disappears, creating a chasm between his desire to belong and his ability to do so. The request by an eighty-two year old minister of ". . . perhaps I could be useful somewhere . . .," is an indictment of the paradox confronting the older adult—that of trying to remain a contributing member of a society which is taking away his opportunity to do so.

When opportunities for getting together with others are limited, it is difficult to find friends, to maintain a proper balance between physical and mental well-being and to contribute to the community.

Organizations, as the form of every human association for the attainment of a common purpose, are the instruments whereby people will work together and they encourage participation in community life. It appears that there may be some place for older people in the regular activities of many organizations. However, without special attention and special activities, very few older people will participate in the life of the community, for most opportunities are geared to meet the needs of younger people. Until the time comes when our society will have adjusted its attitudes toward the older age group, I believe older people can be served more effectively by organizing centers, clubs and activities especially for their use. After becoming securely established in these group settings, the senior citizen can more easily become an integral part of the many phases of community activity and service.

One of the premises in working with older people is based on the philosophy that a major goal in human living is contentment. This calls for continuous social adjustment which can best be achieved by living a positive and socially useful life. It has already been stated that membership in a group is a primary means for senior citizens to remain contributing members of the community. It is only now that we are beginning to discover that the group offers to the older adult, too, the opportunity to keep related to the mainstream of community life.

The senior citizen club worker, who recognized the ability of a former leather worker to teach his craft to other members and eventually to all types of groups, regardless of age, achieved two things. He provided for recognition and useful activity, each a component necessary for the personal well-being of both the teacher and the ones learning the craft. Seventy-four year old Mr. O. turned his former avocation of photography into his secondary occupation. It was not an immediate or abrupt change.

It took a period of eighteen months; first, to interest him in a group; second, to re-build his confidence in being with all kinds of people; third, to regain his self-esteem by showing his skill to his club members; and fourth, to move into other older age clubs where he demonstrated his ability and finally to the point where he taught photography classes in his community.

Then there was Mrs. N., a sixty-seven year old woman, who, at her initial club gathering, never said anything unless spoken to, and who finally asked to serve as her club's representative at a gathering of many organizations in the city. Only a few months earlier she had been unable to accept responsibility for the simplest of tasks. Then she began to serve coffee. When she made her request, she stated she never had a chance to do "those things before," being a housewife, and now she "wanted to learn." Not long afterwards she volunteered her services to a youth serving agency.

It is countless illustrations like these that demonstrate there is a key to combating the feeling that one has no role to play in society. The report which reads, "Mrs. K. is lonely; very much interested in some old people's activity; no special interests," is a theme which has been repeated over and over again, crossing all economic barriers or other social distinctions.

It becomes increasingly clear that in helping older adults to keep related to the mainstream of community life, a two-fold approach is necessary. Every possible means should be explored to provide opportunities for those older people who are still active, to remain active. Further, there should be an intensification of effort for the "social rehabilitation" of those older people who no longer are contributing to society. Here the active older adult can find a fruitful source of satisfactions through service to those older people who have become liabilities to their community. People are living to an older age, and old age brings increasing probability of disabling illness. As a result, many older people are confined permanently or for long periods of time to their homes or in bed. The need for friendly visiting through which volunteers offer friendly help to those confined to their own homes is indicated. It is by this method that the confined older citizen may have letters written for him and read to him, may learn simple crafts and find new hobbies and interests to the limit of his capacity. Here is an enormous resource for community activity for the active older adult on behalf of his less fortunate peers. One seventy-four year old woman, confined to her wheel chair and bed because of arthritis had, ". . . tried to be cheerful and not complain about her disability, but occas-

ionally failed in her efforts." Not long afterwards seventy-six year old Mrs. N. came to chat with her. Several months later the report read, "She no longer brooded . . . (as) she spent most of her waking hours in the wheel chair instead of in bed as she formerly did." Her visitor got her interested in knitting mittens for her husband, even though she was handicapped by arthritis. The smile and chuckle of a feeble ninety year old in a nursing home, who eagerly awaits the regular trip to her eighty-six year old visitor, is the kind of reward that makes her look forward to her visits.

A city-wide hobby show for older people is a further means of spotlighting the creative ability of older people. New interests can be discovered while opportunities abound for deserved recognition, praise and status. I recall a senior citizen club that participated to a very small degree at one hobby festival. At its first group gathering after the hobby show, an eighty-one year old member roundly berated her club members for their lack of community spirit. The club responded to her verbal spanking by proposing and implementing plans for their part in the next hobby show. This same member had never taken a leading part in any venture. She had raised her family and devoted herself to her household tasks until she lost her husband several years back. At her first meeting Mrs. B. had stated the hours weighed heavily upon her. Now she had a consuming interest. Mrs. B. accepted the responsibility for insuring a full representation from the club in the next hobby festival and, on her own, not only initiated plans for a club hobby show but got several members to exhibit at the state fair.

At a subsequent holiday festival, the talents of those who had been active in community life were put to use. Mr. A., because of his many years in the accounting and insurance business, took over the post of treasurer, wherein he stated he "hadn't been so happy in years." And what a job he did in soliciting services and funds. It was reminiscent of the activities of a home for the aged which has realized its importance as a vital part of the neighborhood in which it is located as well as the community of interest to which it is attached. Here the residents solicit for the community chest campaign.

Group life *does* afford the opportunities for remaining a contributing member of the community. Mrs. R., who was a former organizer for a fraternal insurance organization, remarked with great feeling, "The club is a wonderful outlet to do the thing which I know best how to do." Currently, she is organizing several interest groups for older people.

It must be remembered that it is perhaps even more important to provide qualitative associations for older people than quantitative opportunities. This is true even for those older adults who have always been active, for many find increasing difficulty in remaining so. The retired teacher, who had prepared lectures on ten favorite subjects, took a new lease on constructive living when the thirty clubs for older people in his city made bids for his services—each new contact built into another. It has also become possible to interest many older people who have never really participated in any community venture, to contribute —for the first time—their time, effort and varied skills to the betterment of their neighborhood. Some have had to do it as a member of a group which acts as an entity, such as the club which went on record to secure a much needed bus service in their suburb. Again, there are those who are contributing individually, apart from the original group tie which gave them the initial push, like seventy-nine year old Mr. H., who is now teaching Sunday School. Still further, there are those senior citizens who, at the very minimum, are not a liability to the community and who have become socially rehabilitated, as for example, Mrs. N., who refused to take care of herself. She had trouble with circulation in one of her legs. Medical expenses mounted, yet she refused to help herself. In her opinion, life was not worth the effort. Yet, she did get out of bed when directed to a neighborhood club, and when last heard from was going to run for president.

A brief glimpse into the immediate future must include a statement about the giants of industry and labor. Their very position points toward increased recognition of their responsibilities for leadership and participation in keeping the older adult active. Present employees or union members as well as those being retired, by and large, retain their loyalty to the plant and/or union. A group, based on these loyalties, certainly can contribute in some manner to the firm or union as well as undertaking activities not directly related to their work ties. Surely there are many "fringe" activities which are considered so because of the pressure of day-to-day operations in which the group and its members may be able to assist. Some of the outlets suggested here are the church, plant, union, and philanthropic endeavors, among others. The group has been suggested as a major resource in keeping people alert, interested, curious and constructive.

Throughout life man identifies himself with the many groups to which he is bound. Group life provides the necessary funda-

mental support for the functioning efficiency of its members. Group identification promotes self-esteem and occasionally prestige. The individualistic concept of assuming a person can exist in the abstract and be literally independent has been negated. The group is one means of seeing that intellectual capacities are utilized to a maximum. It is one answer to meeting the need to have people function at their highest level of ability.

These, then, are some of the many parts that make up the community, yet they are inseparable to its continued functioning. It is not only possible to help the older adult keep related to the mainstream of community life—it is even more probable that he can shift the course of this stream if given equal opportunity with those of other ages.

USING THE UNIQUE CONTRIBUTION OF LATER MATURITY FOR THE WELL-BEING OF THE COMMUNITY

By Georgene E. Bowen,
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Health and Welfare Council, Philadelphia

It may well be that group work, with its group influence and atmosphere, has done more to attract the community to the older adult than has any other single influence in our time. By its very process of organization, it has brought together isolated and unrelated individuals who have been perforce retired to lives of inactivity, economic limitation and social starvation. Within the group it has naturally substituted new companionship for absent friends. It has offered new and interesting activity to replace enforced idleness. It has accepted whatever strength or limitation the older adult brings with him. It has encouraged him to build upon those foundations and to reach out to new areas of achievement. And all of this has happened as though upon a stage, where the scenery is attractive and the older people perform naturally and harmoniously. Their actions have attracted and fascinated the observant citizenry to whom admission was welcome and free.

It was not until those isolated older individuals in our communities passed over the threshhold into the cordial atmosphere of a hospitable group of their contemporaries that it was possible for the average citizen to imagine what change could be wrought in their personalities. He has now seen the older people in a new and flattering light. The impact of this transformation has been surprising and appealing.

To those who have had experience in the organization of clubs or day centers for older people, a description of the newly enrolled members is no news. Most of them approach with timidity and uncertainty. Among them are those who are convinced of their own inability, easily discouraged, sensitive and sometimes suspicious. Others may be aggressive, compulsive talkers, dictatorial or uncooperative. Of course, these are some of the attitudes of unhappy, unadjusted older individuals that have in the past prejudiced the community against them.

To the average citizen and the uninitiated group worker the almost immediate tempering of unpleasant attitudes comes

as a surprise. The group easily becomes a unit of eager, friendly, cooperative, contented adults. Individuals in the group seem to come to life again. They gain confidence, increasingly take part in the planning of their programs and develop an interest in one another. From concern for the members of their group, they move on to take an interest in the welfare of their community. As they come into their own within the group, they often reveal and use many of the inner qualities that rightfully belong to later maturity.

Perhaps in part because the older adult has considered himself useless, unwanted and out of the stream of life, he has often reacted as an individual in unpleasant ways to the hated situation. He has not often been challenged to contribute his best.

Certainly, the American community in its frantic preoccupation with making a living has heretofore not been impressed with the winsomeness or the general value of its older citizens. They have often seemed to be a social and economic burden. If the average citizen thought at all about age, he probably regarded it as something inevitable that had to be put up with—in others.

He must have been aware, and felt some anxiety about, the illness and possible crippling that the last of life can bring. As he himself grew older, he probably felt a vague dread of what the future held. To him old age was a Dark Age.

Now the older people in group work settings across the land are changing the attitude of the average citizen, and with it they are making their first great contribution to the well-being of the national community. They are quietly and forcefully pressing the point home that age can be something to look forward to. By their example they are giving the community *hope* and *courage* for the future.

There are also, of course, some spectacular examples of gifted individuals. Why is it that a few older people of our time have attained and held the spotlight of public interest? Why is it that all of us take so much pleasure in the dramatic achievements of Grandma Moses, Bernard Baruch, George Bernard Shaw, Arturo Toscanini and Albert Einstein? They have proven to the world that primitive genius can flower at eighty; that the judgments of later maturity can be a pearl of great price; that the talent, art and intelligence of aged persons can reach tremendous heights—and depths. Beyond the comprehension or ability of most of us, we nevertheless gain vicarious satisfaction

and strength from the knowledge that human beings can be triumphant in their old age. Can we not believe that more triumphant age can be the rule and not the prerogative of exceptionally gifted people? With time and patient effort can we not help bring this about?

Perhaps, in the long run, the contribution of little people to the well-being of the community will be even more important, because there are so many little people and because lesser lights are needed to transform the many small dark corners of our neighborhoods. As we take these little old lamps off the shelves, and help to light them again, ought it not to be the group workers' next duty to give them confidence in the usefulness of their latent powers?

There are many instances of the sort of inspiration older people can give. There is the Happy Age Club, for instance, where the aged members were entirely absorbed dancing to the rhythm and swing of the Freilich when our photographer snapped them. All the pleasure, the vitality, the capacity for enjoyment of that moment was caught by the lens. The resulting photograph became an inspiration to all who saw it for, in the center of the group, gaily swinging his partner, was an eighty-eight year old man who had been hospitalized with a broken leg only two years before. He and this buoyant dancing group became the symbol of endurance and life as the community celebrated the Centre's sixty-fifth anniversary and looked forward to its future usefulness.

There is another "little person" who is affectionately regarded as the Grandmother of the Negro community in which she lives in Philadelphia. She belongs to an interracial group of older people who meet at Friends' Neighborhood Guild and she takes an active part in the agency's program. Recently a hearing was held to determine the final distribution of an estate which was left in 1874 for "soup societies" and "freedmen." Since Gram is herself a freed slave she is a claimant to some of the residuary funds. On the stand she fearlessly answered questions and told the story of her childhood. Her father was a cook in the "Great War," she said. Thinking to check her incredible story a lawyer asked, "What war was that?" But she was not in the least confused. "It was Mr. Lincoln's war," she firmly stated. Limited by the circumstances of her early childhood, and unquestionably throughout her life, she still has clarity, intelligence and social concern at 103. She is an inspiration to all who know about her.

One old gentleman who belongs to the group at the Charles

Knox Home in Wynnewood, Pennsylvania, never misses a meeting of the Club except during the Christmas season. At this time the community claims his service because he looks and acts and chuckles exactly as Santa Claus should. He is so gifted in his approach to children that parents and children alike adore him. His contribution to the community is very real as he holds court in the toy department of a prominent store, dispensing cheer, tenderness and understanding. The spirit of Christmas would not be so real without him.

There are older people in most communities who are well able to help with the planning of leisure-time activities—and in Philadelphia they do. Our Advisory Committee on Recreation for Older People is chaired by Mr. Stanley R. Yarnall, who proudly boasts of being an octogenarian. On this Committee with him are other intellectually gifted older people. Without their wisdom and patient guidance we could have made little progress. On the sponsoring committees of many of our eighty-nine older adult groups there are older citizens giving valued guidance and counsel, so that they are active at all levels of planning.

There are many qualities of personality which later maturity is uniquely qualified to use. They are the ones which may grow strong and valuable in proportion to the years of their use. They are not physical nor necessarily mental. They are qualities of the spirit—courage, serenity, dignity, sympathy, wisdom, experience, gratitude, devotion, patience, insight. These deep quiet qualities are the very ones our modern harrassed community needs in order to survive. We all need them desperately. Younger people have them, to be sure, but never to the degree that they can be found in the aged. This degree is the unique possession of later maturity.

I might be justly criticized for giving a prejudiced view of the contribution of older people if I were to overlook the negative characteristics which, when sharpened by years of use, can be very destructive forces in the community. I do not want to evade this fact. I want to face it. There *are* older people who can and do destroy the harmony and health of their families. (We had two of them in my own family.) All of us must know some of the others who have set back their community by stubborn and bitter opposition to progressive legislation. What can be done about them?

If life could give them and me a second chance, I would like to see what could be done with them in a Golden Age Club! I'm sure it would have helped these unhappy and recalcitrant older

people of the past because I have seen it help those who are like them today.

From personal observation of the progress of approximately 4,000 older adults, and from the reports of their group workers, we know that many older people can and do change. The transformation has been so sudden in many cases and has been so constant, once achieved, that there is much reason to believe in the shallowness of many seemingly ingrained destructive personality traits. They continually demonstrate my thesis that if most older people can become accessible to the group work process they can more nearly make their rightful and unique contribution to society.

By no means an exceptional example is the old gentleman whose daughter's marriage seemed hopelessly on the rocks because his attitude in her home had practically destroyed it. When he joined a club group, his behavior in the club and at home so changed that the daughter's marriage was saved. The thankful son-in-law told the story when he contributed generously to a leisure-time project for older people "so that other homes like mine can be happier."

The group work process can be a therapeutic force in the lives of older people, and this in turn can release the latent constructive and spiritual qualities in many of our older citizens. If our work were to accomplish nothing more it would be worth many times its cost of operation to the community.

Dr. Martin Gumpert gave an outstanding paper at the Second International Gerontological Congress in September, 1951. In it, at several points, he touched upon our thesis. He said, "Our human lifespan is so organized that the climax of physical vigor and of mental maturity never coincide. . . . As it is, mental maturity, if achieved at all, is centered deep within the period of physical decline: so deep that it almost seems to be the prerogative of a highly advanced age. Up to the present moment of our history, mankind has tremendously increased in body but profoundly deteriorated in fabric. Perhaps, however, it is the part of nature's imaginative wisdom to improve the substance and the face of the human race in this century by rapidly multiplying the number of old people."

Across the ocean in Switzerland, Dr. Frank Obrecht, a Swiss psychiatrist, published a study of his country's twelve "Centenarians," in which he came to conclusions that give our convictions even more strength. He wrote, "What impressed me most in all these interviews was—aside from their unbroken

vitality—the very distinctive emotional attitude of these old people, which can hardly be described in words . . . . Again and again I came under the spell of this unfailing serenity and clarity, of this extreme modesty, gratefulness, humility and faith in divine providence . . . . Whoever has had repeated contact with persons that old . . . will have felt, like me, that these, our oldest citizens, have not enough influence on our thinking and on the actions of our hurried time. . . . We could learn again from them how to smile and how to understand. We would be closer to the real wisdom of living and to a real peace of mind and peace among nations, if we would once in a while meet with these wise old people and listen to them."

Believing as Dr. Obrecht does, I take the opportunity to tell the groups of older adults in our tri-county Pennsylvania area that they have a unique contribution to make and that we all in every community need whatever of these spiritual qualities they can impart to us.

They listen with breathless attention as though they were hearing of this possibility for the first time—and it is almost certain that they are. Where have older people in our day ever been told that there are spiritual qualities which they are uniquely qualified to give? How can we expect them to make the effort unless someone tells them of the possibility and of the need? Many fortunate older people have reached the goal by the accident of circumstance, or strength of character, not realizing in so doing what a constructive influence their lives have been. There are too many instances of the strong and wholesome influence of later maturity to believe that it is just a coincidence.

Why can it not be a part of a master plan? Does it not make sense that since human beings do not perish as do plants, insects and many animals, with the termination of fertility, mankind continues to survive for other than physical reasons? Is that why the greatest mental maturity is found in highly advanced age? May not the longevity of man be a necessary part of the master plan to give time to develop fully the rarest values of all—mental and spiritual maturity? If older people could themselves believe this, would it not give them the best possible answer to "Why am I alive?" Would it not give them the greatest possible incentive to strive on for the goal of their own best possible achievement?

To summarize, it has been our privilege to help many of the older people of our community come into their own. They have advanced from isolated individuals, uncertain of their own

worth, to interested active members of their group, to materially contributing members of their community.

When we embarked on this project a few years ago we knew we were called upon to pioneer. There was not sufficient evidence then to be sure we could accomplish more than to relieve the monotony of older people and give them friends. Now we know that our project brought them mental health and a new joy of living.

Having brought them along to the point where they now are, shall we as group workers call our task complete? While we are pioneering why can we not press on with our project until we have helped the older adults and the public at large to understand that later maturity has a unique contribution to make to the well-being of every community?

THE FRIENDLY VISITORS TO THE AGED PROGRAM

By Mary A. Young,
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Friendly visiting is probably the oldest technique in social work. In the very early days before charity lost its true meaning, this was how social work was carried on. It still obtains in many church and fraternal groups. In fact, when the Chicago program was started, the planners tried their best to think of another name for their program, but always they came back to "friendly visitor," as the only term which properly described the work which was to be done.

The idea for such a program was actually conceived when a review was made of persons sixty-five or over who were known to a family agency. This was in the late 1930's. In this review the need for someone to take a continuing interest in these elderly people was very marked. Occasionally a caseworker was able to give the additional time but this had to be the exception since more urgent and pressing demands were made upon her. Cases of this sort were generally of long duration and were time-consuming. Caseworkers in public agencies often expressed the wish that their old people could be visited more often.

Although there was contemplation of a program for several years, it did not actually get under way until 1946. During this time it became more and more evident that there was a need for such a service. One private agency had experimented successfully with volunteers to aid in situations on which the agency acted as conservator for funds. The volunteer would visit the client with the twofold purpose of a friendly visit, plus aiding the agency to put the money to the best use.

However, the need was far greater than that which fell within the function of one agency. So the Welfare Council, through the cooperation of the Committee on the Care of the Aged in the Division on Family and Child Welfare, plus the Volunteer Bureau, organized a Volunteer Planning Committee to work with the Bureau to evolve a program. People selected for this committee were professional staff members of public and private agencies having programs for the aged and lay

representatives of the Volunteer Bureau. Public agencies especially emphasized need as their case loads were large, sometimes as many as 250. Visits could not be made more than two or three times a year and sometimes not that often. The visit was chiefly for business reasons, to determine eligibility or because some emergency had occurred. Often caseworkers were unaware of serious problems until it was too late to do much about them. Visits were usually short, caseworkers changed frequently, and the old person seldom was able to establish a relationship. Also, in some of the private agencies and institutions the old person had little or no contact with the outside world.

As the Planning Committee considered the program, several things stood out clearly as being essential if the plan was to succeed. First, there must be careful selection of the volunteers by personal interviews; second, there would need to be a preservice orientation and training of the volunteers in preparation of their duties; third, there would have to be an established relationship with a responsible agency which would select the old person and would give supervision to the volunteers.

Careful selection of the volunteers is very important. In this particular work the volunteer often has a much closer contact with the client than does the caseworker, particularly if the client is an old age pensioner. This being true, the volunteer becomes a liaison between client and agency. Very often, if the client feels neglected or abused, the volunteer may be the recipient of a good deal of hostility. She will need to know how to accept this without getting personally involved. Some of the situations encountered may arouse in her much emotional sympathy which may affect her own attitudes and she may become too closely identified with the client. This may prevent her from remaining objective and consequently her value may be lessened. It is essential that she have sound judgment so that she will be aware of problems which are actual and those which may be imminent. It is her responsibility to keep her supervisor informed on pertinent happenings but not to burden the supervisor with trivia and inconsequential things.

It may help in pointing this up to give an illustration. One volunteer assigned to visit an old lady was confronted by a stolid and seemingly hostile silence. This was repeated on many visits. However, the volunteer had been selected because she could accept such a rebuff and unresponsiveness in a warm and objective manner. Gradually the old lady responded to friendliness and was able to accept the volunteer. Often volunteers are the first to see physical or mental changes. They must be alert

and use judgment in reporting such conditions to the agency and following through on them if necessary.

It is, of course, difficult to differentiate among the three essentials. They are, in face, of almost equal importance, and the lack or failure of one will decrease the success of the program. It is inconceivable to think of sending a volunteer on such an important mission as visiting without proper orientation and training. The Volunteer Bureau planned six sessions (once a week for six weeks) for its recruits. This is usually given twice a year. The most recent one given is typical of the program. The six sessions were:

1. The movie "V for Volunteers" which gives a general portrayal of the use of volunteers in the field of welfare services. A review of what older people need and want. This was presented by the staff secretary in charge of the aged program in the Council.

2. The medical problems of aging, including some special emphasis upon the needs of the chronically ill.

3. How a friendly visitor could serve a welfare agency.

4. A psychiatrist discussed the psychological and emotional needs of older persons.

5. Recreation and craft services for the homebound were presented by an occupational therapist. A second portion of this period was on the use of recreation and group activities. This included a visit to an Old Timers Club in a settlement.

6. Attitudes and methods in friendly visiting. The leader of this session was a caseworker who had had experience supervising friendly visitors.

Each session allowed for a discussion period after presentation of the subject matter. A part of the training also was a "refresher session," after the volunteers had had some experience.

The third essential in the program, that of supervision by an agency, was built around a set of standards which were recommended for agencies using volunteers. Since these standards represent planning derived from experience, it seems important to present them as they were written by the Volunteer Planning Committee. It was the considered opinion of those responsible for the program that these standards were a *must* if agencies and volunteers were to work together successfully.

1. The agency requesting volunteer service from the Volunteer Bureau should be approved by the appropriate division of the Welfare Council of Metropolitan Chicago.

2. Requests for volunteer service should not be for the type of work for which there are budgetary funds available for paid staff. The service of the volunteer should supplement, not supplant, that which is rendered by paid staff.

3. The agency in making requests should give a detailed description of the kind of service to be performed by the volunteer, and pertinent information concerning the person, or persons to be served.

4. The agency should have a program of orientation designed to acquaint the volunteer with the policy, structure, and program of that agency. This orientation should include:

a. Some explanation of the function of the agency and the authority by which it exists;

b. A discussion of the structure of the agency and how the individual volunteer's responsibility, or assignments, relate to the total program;

c. An explanation of the agency's policies, procedures and regulations together with a differentiation of function between the caseworker and the friendly visitor;

d. An introduction to members of the staff with whom the friendly visitor will be working, and a tour of the agency or facility.

5. The agency making requests for volunteers should have a plan for the supervision of volunteers and assume responsibility for seeing that the volunteer program is operating adequately. This plan should include:

a. Relationship to Volunteer Bureau—Each staff worker responsible for supervising volunteers should become familiar with the operation and procedures of the Volunteer Bureau.

b. Staff—The agency should provide professional supervision for each volunteer assigned to the agency.

c. Time—The agency should allow sufficient time for the professional worker to supervise the volunteer.

d. Reports—Attendance reports should be submitted monthly on forms provided by the Bureau. Evaluation reports are to be submitted periodically at the request of and on forms provided by the Volunteer Bureau. Before such forms are submitted to the Volunteer Bureau, they should be used as the basis of supervisory conferences with the volunteers.

That friendly visiting appealed to many people was evidenced in the fact that in the first call for recruits, there were seventy-one women who responded. Out of these, forty-eight were selected. About half of these were business women who wanted to serve on week-ends or evenings. This pioneer group was assigned to ten agencies, public and private family agencies, homes for the aged, services for handicapped, and the County Hospital.

The volunteers became so vitally interested in the service which they could give and in the whole field of geriatrics that they wanted to meet again to talk over the problems they encountered. So in February, 1947, they organized the Friendly Visiting Volunteer Corps. They meet monthly with programs planned about the many aspects of aging. Some of the subjects have been: "The Attitudes and Behavior of the Aged," "Old Age Assistance Program," "Handcraft for the Aged," "Psychological Problems," and field visits to hospitals, Old Age Clubs. Now the Corps has 146 members who serve sixteen agencies.

The Volunteer Bureau also assumes responsibility for recruitment. It has enlisted many channels such as radio, newspapers, the churches. It often presents its program to civic groups and to women's groups interested in welfare services.

The values of this program are great and far reaching. The direct service values cannot be minimized. Many old people, both in the public assistance and voluntary agency programs, because of physical infirmities, are cut off from the outside world. They have a lonely and monotonous existence circumscribed by the four walls of a drab room. The agency worker is often too pressed by large caseloads to be able to give the attention she knows is needed. Here is a resource to which she can turn to lighten her load and to make her job more effective by giving her more hands and feet and by so doing bring the day-to-day world of events to her clients. She can be more certain by the use of trained volunteers that crises will become known to her.

To the people visited, things almost miraculous seem to happen through the dynamics of human relationship. Those of

us who get about easily, who have substance, who have friends, sometimes take for granted what it is that makes life worth while. This is the simple formula of friendly visiting. The ability and the desire to convey to another person that he is still wanted, that he can still be able to derive a thrill out of a friendly relationship with another. Aging can be very frustrating as the person gradually feels that he is no longer needed and that no one particularly cares what happens to him and he in turn may not have anyone that he can care about.

Some of the stories of the volunteers tell this graphically. For example, a young woman volunteer was assigned to visit a frail old lady who had not been out of doors for many years. She had a great fear of walking because of a knee ailment, and there was no one to help her. The volunteer offered to accompany her and together they took walks, first only a block, then several blocks, and finally a visit downtown and lunch in a restaurant —a thrilling experience in this adventure-starved life and one which gave her something to think and talk about.

A woman bedridden with arthritis was a problem to the attendants of a nursing home because of her depression. A volunteer persistently, in spite of rebuffs, worked to divert her from her ingrown thoughts. Gradually she succeeded in getting her to respond cheerfully to her surroundings and take interest in something beyond herself.

Another instance of arousing ill people from apathy was a visitor who could speak a foreign language. She visited a ward of a hospital where there were patients who had had no visitor who could speak their tongue. Your imagination can tell you the joy and warmth with which this visitor was received when she could talk with them in their own language and about their homeland.

Men, too, can participate in friendly visiting. One man volunteer brought cheer to a housebound old gentlemen by helping him develop a hobby of window-box gardening. Something bright and growing brought many happy days and much interest to this physically restricted life.

Sometimes the visitor's chief role is that of a listener to someone who needs to renew himself by recounting exploits; frequently the volunteer can aid a diffident person to broaden his horizon, reviving church relationships, or in joining other groups.

On the other side of the coin are values too, such as the

excellent interpretation of social services to lay people. This service is something real. Volunteers get to learn first-hand how social agencies meet human needs. It was interesting to see how they developed in their understanding of agency problems. In their first visits they received many complaints about agencies, and they felt that agencies were not doing all they could. At the group meetings with the supervisors present, the limitations of agencies were analyzed and interpreted. Volunteers understood the "whys" and were able to handle complaints more positively and effectively. They in turn became interpreters also to the new groups of volunteers. They learn, too, of some of the broader causative factors which create social problems, and through their own group programs learn about what preventive measures in medicine and social services are being developed to combat and treat physical and social ills. This all adds up to a more enlightened supporting public for health and welfare services.

Last, one cannot stop without pointing out the direct value to the volunteer who, if she continues her work, is deriving a great deal of satisfaction by knowing that she, too, is needed and is an essential part of her community. So the values of a Friendly Visiting Program are indeed great and the ramifications within the social welfare structure of the community are as varied as our individual creativeness and imagination will permit them to be. A final word of caution, however—such a program must have soundness of organization which must include careful selection of recruits, discipline of training and protection of supervision.

NEW DEVELOPMENTS IN SERVICES FOR THE AGED-- THE MEDICAL PROGRAM IN A HOME FOR THE AGED

By Edward Schultz, President, The Montefiore Home, Cleveland Hgts., O.

I was told that "Twenty-five years of volunteer service as a Trustee, Member, Chairman of various committees, and President of the Board of Montefiore," would entitle me to talk about the development and progress in the care of older people.

Prior to the Presidency, I had been Chairman of the Intake Committee of Montefiore Home, a spot that controls the pulse of the agency. I lived *through and with* the radical changes which the last years brought into the field, developments which today are taken as a matter of course, but were revolutionary a decade ago. I always had the feeling that our old people should be provided with the best that is possible, and I still feel that way, but I have also learned that it is more important for the happiness of the old person to let him do things for himself rather than do it *for* him or have everything handed to him. I have observed that activity and self-expression do not have to stop at a certain calendar date, but should go on and should be merely modified along with the changes in our capacities.

A radical modification in our thinking as to what constitutes adequate care for old people has taken place within all of us. When I saw for the first time at one of our festivals in 1941 six old people put on a dramatic skit which one old couple had written, I could barely trust my eyes. When, shortly after, I saw on the program of one of our parties "the grand march" I was alarmed; I expected a heart attack of one of these oldsters who were dancing, at any time: I was shocked into one new experience after the other.

Another surprise was when I was confronted with the idea of allowing a shoemaker to bring his machines along to the Home and continue with his work. I had to convince my fellow Board Members that a man who had been working for about fifty years with these machines, does not necessarily cut his hand off on one of them, just because he is using them in an old folks home. I realized long ago that the fact that this man could continue his trade in the Home most likely postponed the progress of his ailment (he was paretic) and kept him a useful contented member of our population. He passed away four years ago,

working in his shoemaker shop until about six months prior to his death. His shop was the beginning of our Workshop project.

But a more personal education was mine, when I had to adjust myself to a new idea of admitting people. For years I had been Chairman of the Intake Committee. Two or three of my Committee members accompanied me on my investigation tours whenever we went to visit an applicant in his home, called on relatives and reported our findings and recommendations to the Board. We based our conclusions on impressions of what we saw and heard, and thought our human interest, desire to help and common sense evaluation of a situation were a sufficient basis on which to predicate a recommendation.

It took me quite a while and a number of test cases to recognize that none of us had time enough for the increased detail work that goes into an application process. We observed that a person whose professional education has trained him to look into the causes of a problem may bring us material most important for a fair decision on an application. We saw that a trained worker has to be up to date on eligibility requirements for Aid for the Aged, other public or private relief sources, Social Security and insurance claims, and skilled in working out fair contributions of children towards the maintenance of their parents. The more our intake grew, the more did we come to appreciate that all of this work should be done by a professional worker; not only because the number of applications increased but because the type of cases who applied to us became more and more complex. Therefore, we have our social worker process each application from the initial inquiry through to the point where a full report is presented to our Intake Committee. This Committee then makes its recommendation to the Board for final decision.

Through this careful sifting and evaluation of our cases, our entire intake and intake policy changed. We became convinced that the able-bodied old person should not be institutionalized so as to make bed space available to those in greatest need.

Of course. I didn't foresee the consequences of our changed intake policy. As years rolled by we found ourselves challenged with a chronically ill population of about 120 residents. We added nurses' aides, an orderly, and another part-time doctor. We set up an Occupational Therapy Department, then added the services of a physical therapist. We felt quite sure that in providing all these medical, nursing and ancillary services in addition to our close contacts with the general hospital facilities of Mount Sinai

Hospital, the needs of our changed population were adequately met. However, gradually a still more disabled type of resident requested admission. From one wheelchair patient a decade ago, we now have twelve. While in former years we rarely saw a resident in our Home who had to use a walking device, we now have four walkers in use, in addition to the wheelchairs. Our hospital dining room became too small, our hospital beds were no longer sufficient and mentally deteriorated patients created a disturbance among the chronically ill.

Our Sheltered Workshop program attracts everyone who can walk or be wheeled to the shops. It serves as a valuable support to our medical and nursing services. Residents who would otherwise stay room-bound and fill our congested hospital and infirmary section, are out and occupied constructively, for hours every day.

It was not for me to find the ways and means by which Montefiore might solve these problems, but rather it was a challenge to our administration. I feel our results have been gratifying, particularly in view of the age of our main building now about thirty-three years and the fact that the building was designed and built to serve sixty well aged persons. Our present population is 121, chiefly chronically ill. One hundred are in the institution; twenty are placed in our out-resident department (a boarding home program with the facilities of the institution); and we have one day-care resident.

A continuous review of our needs and facilities, together with open-mindedness regarding specialized advice and guidance brought us gradually to a total reorganization of our medical program. We remodeled our ground floor into a "special service floor for our senile and mentally slightly disturbed residents." This not only freed rooms for the chronically ill in our hospital section but also eased the disturbance created by these patients. Special nursing and attendant's care was provided under the supervision of our part-time psychiatrist as well as service of caseworkers. It is our aim to have a psychiatric nurse in charge of this floor.

The expansion of our Sheltered Workshop also provided space for the Occupational and Physiotherapy Departments on the same special service floor. In an entirely new building adjacent to the main institution, a spacious factory-like structure offers treatment and work space to a much larger extent than our old makeshift facilities could. The new arrangement serves as an immeasurable help and supplementation to our medical

facilities. Even the patients from our special service floor now spend time in our Sheltered Workshops.

The classification of our residents as of January 1st, 1952, was as follows:

Classification	*Number*	*Percentage*
Well aged .....)		
)	4	3.30
Feeble aged .....)		
Blind and limited vision	8	6.60
CHRONICALLY ILL:		
A	20	16.50
B	24	19.80
C	26	21.60
Senile psychotic psychoses	10	8.25
Psychoneurotic	20	16.50
Neurotic	7	5.80
Feeble minded	2	1.65
Total	121	100.00

The needs of this type of residents suggested the following division of medical care:

1. To provide medical care for the chronically ill. The extent of medical care will vary from simply a little closer supervision than that given the well aged in the past to that usually associated with a nursing home.

2. To continue to care for residents who develop chronic progressive, degenerative illnesses or incapacities requiring closer medical supervision than can be given in the resident section and general dining room. For these a working arrangement or understanding with the County Chronically Ill Hospital, at present under construction, is planned.

3. To care for mild acute illnesses developing among the residents. It is believed that these could be handled adequately in the Home, and in many respects better than by transfer to a general hospital because of the difficulty of old people in adjusting to a new environment and the better understanding of the Home staff of their special problems. Adequate utility room space, nurses' office, and kitchen area should be provided.

On this basis our medical program has been geared to: (1) Medical treatment; (2) Preventive medicine; (3) Rehabilitation; and (4) Research.

The administration of this program lies in the hands of our Senior Physician, as supervising chief, and a younger internist on a four-hour a day basis. It is by no means an attempt on our part to run a hospital in the ordinary sense of the word—that is, to provide diagnostic services, surgical care or medical care that would require specialized equipment or specialized skills. All these are provided by Mount Sinai Hospital and other Cleveland hospitals in cooperation with Montefiore Home. Nor are we attempting to equip a chronic disease hospital in our institution. It is the responsibility of the physician in charge to secure specialized medical service whenever needed in the execution of the best medical administration. Since our doctor is also a staff physician of Mount Sinai Hospital, the greatest possible use of all Mount Sinai facilities, laboratories as well as staff, is insured. This holds true in regard to diagnosis, treatment of patients, and research. A Doctor of Physical Medicine is attached to our staff on a part-time basis; he is in charge of the rehabilitation program, while a Gerentologist serves as our consultant for nutritional care. It is understood that our doctor in charge has the responsibility for the over-all program under the supervision of the Senior Chief, mentioned before. While our doctor plays the focal role in the entire program, he utilizes for medical and nursing care, all other services of the Home, as they are carried out by the psychiatrist, social workers, nutritionist and housekeeper. The psychiatrist is consultant to all departments. He carries the final responsibility if the need for transfer of a patient to a mental hospital arises.

Our nursing service is directed by a Nursing Supervisor. The physical and occupational therapists work as part of our medical program on a prescription basis by the Doctor of Physical Medicine. Two further services must be considered in the evaluation of our medical care. They are the casework service which provides interpretation of the patient's social problems to the medical and nursing staff, and the marvelous rehabilitation services which our Sheltered Workshop renders. If I should sum up what constitutes a feasible medical program in our homes for the aged, I would say that it is not the extent or quantity of the physical set-up, but the quality of the staff, and the content of the service which it renders. It is the integrated, cooperative relationship between the various departments, professional and semi-professional staff members, who eagerly use their knowledge and skills not for a specific part, but for the entire welfare of their patients.

Last, but not least, it is the flexibility and the open-minded-

ness with which we, as Board Members, who are responsible for policy-making face the continuous changes of needs and accept the professional findings and recommendations. Upon such principles and good will, our homes can become places which make a reality of the potentials which an enlightened era provides for longer years of life and greater usefulness and, we hope, happiness.

FAMILY CARE FOR OLDER PERSONS

By Louise Magary,
Old Age Project
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We all know that the increase in the elderly population in our country, and in the world, has brought social and medical problems which require our immediate attention. Persons over sixty have increased in proportion to the rest of the population from slightly more than four per cent in 1850 to twelve per cent in 1950. Along with this increase have come changes in the living habits of our people which makes growing old increasingly more hazardous. For instance, the shift of the population from country to city living has almost eliminated the places to which older people in the past normally retired. Houses in urban areas are designed for two-generation families and an automobile. This excludes grandma and grandpa. Financially, a smaller number of children must support a greater number of parents; that is, the tendency toward small families has left two or three children with responsibility for parents, who formerly could have turned for help to nine or ten children.

During the last twenty years, older people have been increasingly consigned to lonely furnished rooms, institutions and, unfortunately, to mental hospitals for mild senile complaints. Many of excellent cultural background have turned up homeless and wandering.

Recently, due to the tireless efforts of a few individuals working in the old age field, the public has become conscious of the problem, this consciousness being reflected in our periodicals, newspapers and finally in the programs of social agencies.

In June, 1950, the Community Service Society in New York set up an old age project, through which the problems of older people were designated for special study. Two caseworkers and a public health nurse were assigned to do intensive work with an average caseload of persons over sixty, exploring needs, providing services and attempting some research. During the course of the first year, we helped seventy-one individuals. A written report on this concentrated span of treatment has been prepared by Dr. Wilma Winnick, a research psychologist. Since the first year's work was completed, we have continually added to the

caseload, so that now we have a sample of 200 individuals over sixty for study purposes.

During the past month, I have been studying the original living arrangements, housing requests and solutions reached on these 200 cases. The living arrangements for the 200 in Queens, a suburban area, break down as follows:

Living Arrangements

(at intake)

Own apartment	77
Home of relatives	64
Property owners	26
Furnished rooms	8
In hospitals	7
In boarding homes	6
In nursing homes	3
In hotels	1
Unknown (withdrew)	8
Total	200

I then made a study of the requests of these 200 individuals and found that eighty-six, or forty-three per cent, were for new housing arrangements. This means that almost half of the individuals who came to us asked for a housing plan, in spite of the fact that the above figures for the Queens caseload show considerable stability of housing, with the greatest number of persons living in their own apartments, on their own property or with relatives. This suggested that some elderly persons need more protective care than they can get in their own homes; and that many living with relatives were having family difficulties.

My next step was to break down the housing requests into categories to see what type of housing was most frequently desired by the client or his family. I found that forty-eight of the eighty-six housing requests were for institutional home placements, which is more than half. Throughout the study, we were suspicious of requests of this kind and gave a great deal of attention to sorting out the applicant's motivations. As a result of our careful study and interpretation of other resources, we arrived at the following solutions:

Solutions of Housing Requests

Placed in institutional type homes	9
Placed in boarding or family homes	16
Helped remain with relatives	14
Helped remain in own home	14
Hospitalized or died	9
Helped take own room	8
Nursing home placements	3
Convalescent homes	2
Mental hospital referrals	2
Helped rejoin a relative	1
Unresolved, or withdrew	8
Total	86

It can be seen that our major solutions involved family care of the individual, either through his own relatives or through a boarding home arrangement which would give him similar values. Maintaining the individual in his own home, in a relative's home or in a small boarding home, through casework help and interpretation, enabled us to strengthen the family and community relationships of each person.

It was our feeling that the need for family ties, or a substitute, becomes more acute as people grow older because of loss of married children, death of spouse, retirement from employment with decreasing social contacts, and lowered economic status which acts as a depressant. It is therefore the caseworker's job to find solutions which will increase activity of the individual, provide companionship, give a feeling of usefulness and establish necessary financial assistance.

In order to evaluate the requests for institutional home placements, we insisted on a suitable exploratory period with each applicant, sometimes lasting as long as three or four months, before making plans. We found that older people do not know the resources in the community; in fact, neither do some ministers, relatives and friends. Ministers, because of their connections with sectarian old age institutions, seem to think most commonly of such institutions as a natural solution for old age. Relatives and friends have heard of these institutions, all their lives; many of them came to us apologetically, saying, "I always knew I would have to put Mother away, someday—I wish there was some other way." They are unacquainted with the widespread availability of Old Age Assistance under the Department of Welfare, through which many elderly persons

can be set up in their homes, or in informal, small, boarding homes; some are surprised to find that the older persons have social security benefits from the Federal government coming to them.

The requests for institutional placements seem to be based on financial insecurity, a desire of relatives to "put the parent away" in a safe place, a desire on the part of the client to obtain life care for one or two thousand dollars he has saved, and his feeling of hopelessness leading to complete withdrawal from the community.

By focusing directly on the elderly individual, seeing him as the applicant from the beginning, and constantly being aware of his necessity to make his own decisions, we were able to keep most of our oldsters in their normal environment.

I might mention that work with elderly persons requires field visits to the home; and any plan to help the elderly in a community agency must make provision for this. Most older people have difficulty coming to the office and the least ambulatory of them may need the greatest opportunity for self-expression and participation.

Our first objective was to see whether family relations could be improved, tensions relieved and interpretation provided which would permit the older person to continue as part of his natural family. This failing, we found small boarding homes, offering family care, the best substitute for the old homestead.

In Mrs. L.'s boarding home, our Miss Ely found herself sitting around a dining room table with Mr. and Mrs. L., their eighteen-year old son, Mrs. L.'s elderly mother who had suffered from a stroke and another aged woman who was boarding. Miss Ely had just lost her sister with whom she had lived in an apartment for twenty-five years; she was glad to have the other boarder as a contemporary companion. At the same time she enjoyed watching television with the son and she could also feel rather contented over her own good health as compared to the feebleness of Mrs. L.'s mother.

Small family-type boarding homes are often run by former nurses who give excellent care to the elderly. Mrs. K., for instance, is not happy unless she is caring for at least one senile person with behavior problems. "I just love them," she tells me. "It's a sort of challenge." With her, we placed Mrs. Casey, eighty-two, who was causing her children much heartache, by running away from their homes, when invited for holiday dinners, accus-

ing them of poisoning her food, fighting actively with daughters-in-law and making pathetic but unjustified complaints to neighbors. Mrs. Casey's history which we happened to have in our agency files showed a lifetime of family and marital difficulties. Yet she adjusted well at Mrs. K's for over a year before a mental commitment was finally necessary. Mrs. K. put her on the ground floor room next to lavatory and kitchen where she watched the preparation of food, offering suggestions, and helped with dishes. She could also sit in the backyard with two other boarders or with Mrs. K's sister. Occasionally the son of the family came home for a week-end, bringing his wife and children.

From an old record we take this account of the boarding home placement of Mr. A., age eighty. For some time after Mr. A. moved into the home, things went smoothly. The entire family took him on as "Uncle Louie" and they were all, including the children, very fond of him. Then Mr. A. became ill and began to deteriorate rapidly. The family had to do more and more for him, assisting him in dressing, helping him at night and sometimes giving bedside care. At no point did the family complain but seemed to enjoy helping the old gentleman. He was taken to the hospital shortly before Christmas and consigned to a psychiatric ward. When the boarding home proprietor visited him there she signed him out and took him home for Christmas. In February, Mr. A. became much worse, and it was necessary to hospitalize him again. Both the boarding home mother and her husband visited regularly; and when the hospital wanted the old man signed into a state mental hospital, the husband claimed to be next-of-kin and prevented the commitment. Later that month Mr. A. died and the family was very much upset. They never seemed to regret taking the old man into their home and felt proud that they had contributed happiness to the last days of his life.

This family later took three other placements, including an unmarried mother, an orphaned baby and an adolescent boy. The attitude of acceptance, warmth and love toward human beings found here had a universal aspect and was not confined to any particular category, just as the warmth and interest of good caseworkers can also be transferred to any group of individuals under care.

The problems faced by these small homeowners who are willing to care for elderly persons must be recognized. Our need was for homes which would charge only $80-90 a month for room and board, the amount allowed by our Department of Welfare.

Almost all our clients were living on this amount, either through the Welfare Department or through various pension plans and relatives' contributions. The obvious disinterest in financial gain draws attention to the motivations of the boarding home mothers, some of whom wanted an elderly person in the home to replace a beloved parent or to act as grandma or grandpa to growing children. Others, elderly themselves, sought companionship in widowhood or wanted to feel useful and responsible for someone again. Nurses enjoyed returning to some aspect of their former profession; middle-aged women, their children married, wanted to fill the wasted space. One woman told us, "I like older people around because they're so wise."

From 1944-1946, our Society operated a placement service from the central office, through which a continuity of work with both the boarder and the boarding home proprietor was attempted. The service included home finding and investigation, foster placement and follow-up care. There was approximately 333 requests for placement during the two years, with 113 of these made by elderly persons. The second highest figure was for parent-child placements. In this earlier study, it was found, as later, that the small family boarding home was the most successful. In recruiting our present homes, we have relied considerably on the records from the former service and have obtained additional homes through newspaper advertisements. We have also learned of good homes through the Department of Welfare and the Social Service Department of Queens General Hospital.

In our current old age study, we attempted to set some standards, most of which we had to discard as unrealistic in view of the payments provided by our clients. For instance, we would like to have seen handrails near tub and toilet, well-lighted stairs with treads, rubber pads in the tubs, bed lamps, covers for all electric equipment and cords, fire extinguishers and a protective lock on the medicine cabinet. Because of the housing shortage and the laws of supply and demand, we could only suggest these things; we needed homes badly and took what we could find. In some instances, preconceived notions about proper equipment for elderly people were overruled through actual experience with their problems.

In New York City, families may board from one to four elderly persons without coming under specific multiple dwelling laws or regulations governing commercial boarding homes. For this reason, the agency making placements in these small homes has additional responsibility to see that they are safe. We were

also interested in the privacy of interviews in the home, whether there would be interference with these, how free the boarding home mother was in showing us about and what the relationships were among her guests. In one home, the proprietor was rather distant and cold, but the elderly person whom we had placed there was very much interested in the children and in the husband who was planning to take her automobile-riding on Sundays.

We had to remember that most of the people we placed had failed in relationships with their own children; therefore, we anticipated that there would be some trouble in the new setting. Casework was used not only to help the elderly boarder understand his own part in these difficulties but also to assist the boarding home mother who leaned on us a good deal for advice and interpretation of behavior. Many of these women could handle the most severe problems as long as we were there at the other end of the telephone to share their burden.

Throughout our contact with each elderly person, we tried to increase the interest of the married children and other relatives in visiting, taking the client home on Sundays and providing a regularity of service, both through a stated monthly financial contribution, however small, and in little chores such as transportation to the beauty parlor, recreation center or shop. Where there were no relatives, the boarding home family took on some of these services, as they were able.

Elderly clients often need a demonstration of a new plan of living before they can accept it. We found that older people do become somewhat rigid about change, especially in regard to housing. One old man stoutly resisted my suggestion of a family-care home, although I had an ideal opening for him. He insisted that his children should take him in and sat stubbornly in the office, clinging to his own unrealistic plan. I finally persuaded him to try Mrs. K's home for a week and assured him that I would help him to leave if he chose. After two nights at the home, he was delighted, saying, "If everyone was as good as Mrs. K., there wouldn't be any unhappy old people in the world!"

The need for boarding placements in family-care homes among the higher income group is seen in the development of a private service, recently started in New York by two social workers. Evelyn Hyman, formerly with the Springfield State Hospital in Maryland, and Ruth Shallit, associated with child-placing in Chicago, have opened their own business which they call "Adult Counselors and Homefinders." Both are graduate

social workers, combining, interestingly enough, the disciplines of the Pennsylvania and New York Schools of Social Work. Their referrals come principally from private doctors and psychiatrists, who are frequently the counselors of the well-to-do. During the past nine months, these young women have developed about 300 family-care homes which charge an average of $250 a month for room and board. The extent of the need is due, they believe, to the long waiting lists in private agencies, the fact that few agencies offer a specialized service and those that do are sectarian. There is little question that agencies with waiting lists are apt to serve elderly people last, because of the limited ability of older persons to press for action and the tendency of caseworkers to concentrate on services to children.

In conclusion, I would like to mention other agencies in New York which are interested in family placement of elderly people. The Jewish Community Service has forty-five such placements under a program called, "Private Residence Program." Catholic Charities has twenty-five placements at this time. The New York Department of Welfare, with Harry A. Levine, originator of the Hodson Center, in charge of planning, hopes to work out a blueprint in which elderly Old Age Assistance recipients will be housed in boarding homes within walking distance of recreation centers for the aged. This would be an ideal arrangement.

With the trend definitely in favor of monthly allowances for elderly people, whether from Old Age Assistance, Old Age and Survivor's Insurance, or other pensions and contributions, we feel that our clients will seek, increasingly, some substitute for family care, which will enable them to remain in their normal setting, go to their own church, shop, chat and mix with friends of a lifetime. Until special housing is built for the aged on a wider scale, the family-type boarding home seems to offer the best solution to the present need.

MILWAUKEE'S RECREATION PROGRAM FOR THE AGING

By Donald B. Dyer,
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The objective of the Milwaukee Department of Municipal Recreation in its "Golden Age" program is to help these people "Add life to years, not just years to life."

The retired and the aged need the same opportunities for self-expression as any other age level; those no longer employed have a "surplus of time" and the need of self-expression becomes exaggerated in order to supply those emotional satisfactions which their former occupations furnished. This group craves attention and affection; they have a great desire to be a part of the stream of normal life, to do the things that others do, to participate, to function, to be effective and to be respected.

Opportunities must be offered which will permit these oldsters to become acquainted with others of their age, to find satisfying companionships, to develop new friends to replace those who have passed on, to find others who have similar interests, to express their creative impulses and to be productive. This is the only way in which they can continue to learn, be stimulated by new experiences and take an active part in directing the course of their lives.

The aged wish to be respected, not only for what they were, but what they are and not only for what they have done, but what they can do. All people need the warmth of understanding friends and the feeling of belonging.

A nationally known psychiatrist has said: "Recreation is an extremely important aid to growing older gracefully. People who stay young, despite their years do so because of an active interest that provides satisfaction through participation. The elderly person with a hobby is almost always an alert, interesting person. By contrast, there is no more pathetic sight than the older person who has no interest in life and only sits and waits —vivid evidence of the value of recreation to mental health. We do not cease playing because we are old; we grow old because we cease playing."

For these reasons, the Milwaukee Department of Municipal Recreation, in an effort to meet some of these needs, offers a

specially organized and conducted recreation program for the aged, known as the "Golden Age Clubs."

History

In 1949, the Recreation Department appointed a full-time director to promote, organize and conduct a year-around recreation program for these oldsters. Today, more than 2,000 men and women are active in this city-wide organization, with 33 clubs—29 of which meet regularly in the social centers of the Recreation Department, three in private agency community houses, and one in a parish church.

Club Organization

Any one sixty years of age or over is eligible to membership. Meetings are held weekly. Each group elects its own officers, has various committees which help in planning the program and activities of the club and conducts its affairs in the same manner as any private organization.

Membership is recruited through the use of many channels, as follows:

1. The Family Service;
2. Visiting Nurses' Association;
3. American Red Cross;
4. Neighborhood churches and synagogues;
5. Homes for the aged;
6. Referrals from public agencies;
7. Letters and invitations to individuals;
8. By word of mouth;
9. Posters and bulletin board announcements;
10. Press, radio, and television.

The Program

The club is a substitute for a family in many cases. A pleasant greeting, a hearty handshake, a birthday party, an anniversary celebration, a get-well card, etc., are all events of tremendous importance.

On meeting days, the early arrivals sit at tables and play chess, checkers, dominoes, or cards, listen to the radio, visit or read. These activities offer splendid opportunities for social contacts, fun, companionship and new interests with people of their own age, and verify the clubs' slogan, "Fun Doesn't Stop at Sixty."

The organized program for the club's meeting is closely related to the particular needs and interests of that group. Speakers are not unusual and a spirited discussion usually follows their remarks. Music, drama presentations and movies are popular program numbers. The formal meeting is followed by "coffee and cake." A small box on a table for voluntary contributions, in most cases, is sufficient to pay for the club's refreshments, to purchase "get-well" cards and to defray other miscellaneous expenses. This procedure gives the members a feeling of independence and self-sufficiency.

Special club events include birthday and anniversary parties for members, holiday parties, community singing, old-time dancing and educational tours. Besides visiting shut-in or sick members, each club has service projects, such as making blankets for disabled veterans, planning, providing and helping conduct children's holiday programs, and making table decorations for the social center's community parties.

When a club is first organized, the members will want to be entertained; it takes a little time to move them from passive to active participation. Older people are quite rigid in their behavior patterns. Therefore, the program content must be geared and tempered to their pace. As group participation and responsibility slowly develop, the members come to rely more and more on their own abilities. That is why the committee memberships responsible for serving refreshments, visiting shut-ins and performing other tasks are changed often.

The All-Club Council

Of major importance is an "All-Club Council" composed of two representatives from each of the Golden Age Clubs. This council forms the planning and steering committee and does most of the coordinating for the all-city activities. The group meets the first Monday of each month. Officers are elected annually and consist of a president, vice-president and secretary. This "governing body," as the council is sometimes called, is very democratic and the programs planned are determined by the available facilities and the expressed desires of the membership.

The All-Club Council assists in the planning of programs which bring the members of all the clubs together for such events as picnics, concerts, card tournaments, entertainments, etc. The "Golden Age Club News" is published regularly and includes news items about individual clubs and members, original songs and poems, human interest stories and letters. It is distributed

to the entire membership free-of-charge. This year the Council sponsored a dramatic production entitled, "The Gay Nineties," planned and produced by Golden Age Club members. The department provides a Central Hobby Shop, which provides an opportunity for all who desire to renew skills or learn new ones and also sponsors an all-city Golden Age Chorus.

Leadership

The backbone of this entire program is the leadership. Good leadership can deal constructively with the individual eccentricities and behavior patterns. One full-time recreation director devotes her entire time to the promotion, organization and supervision of these clubs. She is assisted by two full-time recreation instructors and several part-time leaders, who are trained and have abilities in handcraft, music, arts and game and party planning. The age of the leader is not too important, but it is essential that the leader be interested in "old folks." The same basic group work philosophy and principles apply to the old as apply to youth.

Whose Responsibility?

This period of growing old is a time for adjustments of many kinds and should be the concern of the entire community. There are many needs beside recreation, and the various agencies of the community, private and public, have definite responsibilities. There is need for coordinated planning and action, if the best results are to be attained.

A public recreation department has the responsibility of providing leisure-time activities for the aged as well as for youth; to make the lives of these oldsters happier through an organized program of friendly service, which provides opportunities for social contacts and the preservation of skills and hobbies. In this manner, each one receives mental stimulation, satisfactory social relationships and accepts group responsibilities. The recreation program should never be thought of as an end in itself but should also aid in meeting other needs of the group and the individual members by coordinated action and planning with other agencies.

HPI-52-102

Health Publications Institute Inc.
Raleigh, N.C.
$1.00 per copy